WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 827 File No. 28406

Primary Registration District No. 4300 Registered No. 60

1 PLACE OF DEATH

County: Shelby

Township: Clay

or

Village:

or

City: Clarence (NO. ..... St. ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME: Lewis Franklin Schwada

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): S

6 DATE OF BIRTH: June 16, 1916 (Month) (Day) (Year)

7 AGE: 2 yrs. 1 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: ✓
(b) General nature of industry business, or establishment in which employed (or employer): ✓

9 BIRTHPLACE (City or town, State or foreign country): Mo

PARENTS

10 NAME OF FATHER: Frank Schwada

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo.

12 MAIDEN NAME OF MOTHER: Eva Bird

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Frank Schwada
(Address): Clarence Mo

15 Filed Sept 7, 1918 W. M. Baylis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug. (Month) 3 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 29, 1918, to Aug. 3, 1918, that I last saw him alive on Aug. 2, 1918, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Colitis 103

120B

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. K. Roy M. D.

Aug. 6, 1918 (Address) Clarence, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Ebenezer DATE OF BURIAL: 8-4-1918

20 UNDERTAKER: E. A. Harper ADDRESS: Clarence Mo

1 PLACE OF DEATH

17 5
7 D 40

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.